STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIED IDENTIFICATION NUMBER 1		(X2) MULT A. BUILDII B. WING		(X3) DATE SURVEY COMPLETED 04/15/2010
NAME OF PROV	IDER OR SUPPLIER			DRESS, CITY.	STATE, ZIP CODE	041012010
HELP OF SC	UTHERN NEVAD	A		AS, NV 891		
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by pro- acc average av	the Health Division bibiting any crimitions or other claimallable to any partite or local laws. The statement of Escult of the State your facility on 4/rvey was conducted 9.150, Powers of the facility is licensing and drugs. The state your facility is licensing the facility in the facility is licensing the facility in the facility is licensing the facility is licensing the facili	onclusions of any investion shall not be constituted or civil investigated in for relief that may try under applicable for the properties was generally and the properties of the Health Division. The Health Division of the Health Division of the treatment of abuse The census at the tip Eight resident files and reviewed.	rued as ions, y be ederal, erated as inducted sensure f NRS			Xe.
D 041 NAC 449.102 Inventory of client's belongings SS=B If a facility holds or stores a client's belongings, there must be an inventory of the belongings on admission, made a part of the client's record, and updated as needed. These belongings must be returned to the client upon his exit. This Regulation is not met as evidenced by: Based on record review on 4/15/10, the facility failed to take an inventory of belongings on admission for 2 of 8 residents (Resident #1 and #2). Severity: 1 Scope: 2			D 041	DOUT A. The Cluthing inversed in all intal will be competed intake. B. Case Manager Will cluthing inventory assigned to check the control of the control o		
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Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVS5005ADA 04/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1417 LAS VEGAS BLVD N **HELP OF SOUTHERN NEVADA** LAS VEGAS, NV 89101 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) MPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY D089 V D 089 Continued From page 1 D 089 A Employment Applications will be dotained for all future employees hired. D 089 NAC 449.114(9)(a) Employees D 089 SS=A B. Employee records will be reviewed A personnel record must be maintained for by the Human Resource Director Breny each employee. The record must contain: (a) The employment application le months to ensure complainte Attachment 3 This Regulation is not met as evidenced by: Based on record review on 4/15/10, the facility ر 4-16-10 falled to obtain an employment application for 1 of 12 employees (Employee #1). Severity: 1 Scope: 1 DO90 V A. Letters of recommendation will be D 090 NAC 449.114(9)(b) Employees D 090 SS=C obtained for all Future employees hired 9. A personnel record must be maintained for B. Employee records will be reviewed even each employee. The record must contain: le months to ensure compliance. (b) Letters of recommendation C. 4-16-10 This Regulation is not met as evidenced by: Based on record review on 4/15/10, the facility did not obtain letters of recommendation for 9 of 12 employees (Employee #1, #2, #3, #4, #6, #8, #9, #10, and #11). Mais Severity: 1 Scope: 3 A. Human lescures will verify references For all employees prior to being hired D 091 NAC 449.114(9)(c) Employees D 091 SS≃A References will be Documented and 9. A personnel record must be maintained for placed in employee File each employee. The record must contain: B. Employee records will be reviewed (c) Reference investigation records by the human resource Director every le montres for compliance This Regulation is not met as evidenced by: Based on record review on 4/15/10, the facility Attachment 4+5 falled to conduct a reference investigation on 2 of C. 4-10-10 If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVS5005ADA 04/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1417 LAS VEGAS BLVD N **HELP OF SOUTHERN NEVADA** LAS VEGAS, NV 89101 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) D 091 Continued From page 2 D 091 12 employees (Employee #2 and #9). Severity: 1 Scope: 1 D093~ D 093 NAC 449.114(9)(e) Employees D 093 A. All employees will sign off that they sign attended orientation. SS≃A 9. A personnel record must be maintained for B. Employee records will be reviewed each employee. The record must contain: (e) Documentation of attendance at the eiery le months for compliance. orientation session for new employees: C Attachment le was în employee File on Date of Survey This Regulation is not met as evidenced by: Based on record review on 4/15/10, the facility failed to provide documentation of completed N. 3-17-10 orientation for 1 of 12 employees (Employee #11). Severity: 1 Scope: 1 A. Job performance Evaluations will be a ferformed Annually For each employee D 094 NAC 449.114(9)(f) Employees D 094 by the program Director. The CEO Will SS=A Complete Annual Evaluation for the 9. A personnel record must be maintained for each employee. The record must contain: program Director. (f) Job performance evaluations: B. Employee records will be reviewed every Le month for compliance. This Regulation is not met as evidenced by: C. Employe 348 Ido performance Based on record review on 4/15/10, the facility Evaluations are complete. did not perform a job performance evaluation on attachment 748 2 of 12 employees (Employee #3 and #8). D. 5440 Severity: 1 Scope: 1 D 100 NAC 449.117 Physical Examinations DINO D 100 A.TB Shin tests will be ione prio SS=F All persons employed in a facility must have to employment and Armuelly documentation showing that they are in there after. compliance with any applicable provisions of

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good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and With Complete Lesigner Comple		This Regulation is in NAC 441A.375 Med dependent and home care: Management cases; surveillance counseling and prev 441A.120) 1. A case having tult considered to have facility or a facility for managed in accordadity or a facility for managed in accordadity or a facility for managed in accordadity and the formal facility, a home for individual maintain surveillance or home for tubercu infection. The surveillance or home for tubercu infection. The surveillance conducted in accordate recommendations of Control and Prevent transmission of tube health care set forth Centers for Disease adopted by reference subsection 1 of NAC 3. Before initial empinal medical facility, a home for individual a: (a) Physical examinations of the physician the good health, is free fany other communications of the physician the good health, is free fany other communications.	C concerning tuberous continuities, facilities, facilities for individual resion cases and suspect and testing of employentive treatment. (No perculosis or suspect tuberculosis or suspect tuberculosis in a metor the dependent must ance with the guideline Control and Preventie in paragraph (h) of C 441A.200. The control and tuberculosis and tuberculosis and tuberculosis and tuberculosis and tuberculosis in facilities print the guidelines of the Centers for Discion for preventing the control and Preventie in paragraph (h) of C 441A.200. The guidelines of the Control and Preventie in paragraph (h) of C 441A.200. The guidelines of the control and Preventie in paragraph (h) of C 441A.200. The dependential care shall residential reside	ulosis. I by: s for the dential ted yees; RS ded case dical st be nes of the tion as fendent or all e facility s must be ease e providing the tion as mployed endent or all have from a state of esis and		B. Employee records will every be month for co. C. Employee I obtained and results are at Attachment 9 D. Employee & had positive and had chest xray check was completed and had chest xray. Attachment 10 E. Employee & had positive and had chest xray. A check was completed that chest xray. A check was completed and had chest xray. A check was completed and had chest xray. A check was completed and results are attachment 12 G. Employee & obtained and results are attachment 13 H. Employee be obtained fesults are attachment 14 H. Employee be obtained fesults are attachment 14 Employee Completed le contrained fesults are attachment 14 Employee Completed le contrained fesults are attachment 14 Employee T resigned was completed le attachment.	infinitive. 15++2nd step - teuched39-10 we +8 results ted. 4-39-10 we TB results includ symptom red. 4-39-10 d 15++2nd step oched. 4-29-10 1st+2nd step Ared. 39-10 step includ symptom red. 4-39-10 step step step includ step step	

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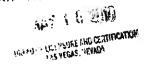
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Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVS5005ADA 04/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1417 LAS VEGAS BLVD N HELP OF SOUTHERN NEVADA LAS VEGAS, NV 89101 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) J. Emplake 8 obtained foother 151 sta D 100 Continued From page 4 D 100 result and was sent for x-ray, r (b) Tuberculosis screening test within the Attachment 14, 17, 18, 19 5-6-10 preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) K. Employee 9 obtained 15+2nd skp vaccination. and results are attached. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the Attachment 20 4-30-10 preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other L. Employce to had positive TB results single-step tuberculosis screening test must be and had chest x-ray. Annual symptom check was completed. administered. A single annual tuberculosis screening test must be administered thereafter. unless the medical director of the facility or his Attachment 21 4-28-10 designee or another licensed physician determines that the risk of exposure is M. Employee 11 dotained 1st + 2nd skp appropriate for a lesser frequency of testing and documents that determination. The risk of and results are attached. exposure and corresponding frequency of Attachment 22 4-30-10 examination must be determined by following the N. Employee 12 had positive TB Results and had Chest X-ray. Arrival L guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. Symptom check was completed. 4. An employee with a documented history of a positive tuberculosis screening test is exempt Attachment 23 4-29-10 from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. A. All employees will obtain remployment physical prior to being hired.

B. Human resource Director will review D 100 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. Counseling and preventive treatment must be offered to a person with a positive tuberculosis Files every le months for compliance. screening test in accordance with the guidelines of the Centers for Disease Control and C. Employee 1 Obtained physical Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. Attachment 24 4-26-10 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of the state of th



Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVS5005ADA 04/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1417 LAS VEGAS BLVD N HELP OF SOUTHERN NEVADA LAS VEGAS, NV 89101 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D. Employee 2 employment physical. was in the file. D 100 Continued From page 5 D 100 report promptly to the infection control specialist, Attachment 25 10-30-08 if any, or to the director or other person in charge of the medical facility if the medical facility has not E. Employee 3 employ ment physical ~ designated an infection control specialist, when any pulmonary symptoms develop. If symptoms was in the file. Attachment 26 11-14-08 of tuberculosis are present, the employee shall be evaluated for tuberculosis. (Added to NAC by F. Employee 9 obstained physical. Bd. of Health, eff. 1-24-92; A by R084-06. 7-14-2006) Attachment 27 4-22-10 6. Employee 11 dotained physical— Based on record review on 4/15/10, the facility did not ensure that 11 of 12 employees met the Attachment 28 4-29-10 requirements of NAC 441A.375 concerning tuberculosis (TB) (Employee #1, #2, #3, #9 and #11 failed to have evidence of a pre-employment physical. Employee #1, #2, #5, #6, #7, #8, #9, #10, #11 and #12 failed provide evidence of tuberculosis.) Severity: 2 Scope: 3 DIG 1 D 168 NAC 449.135(6) Safety from fire D 168 A. Fire Drills will be londucked monthly and bournenked. SS=F 6. A facility must conduct fire drills at least monthly and a written record of each drill B. Program Director Will Check Fire conducted must be retained in the facility for not Drill log monthly to ensure comploance. less than 12 months after the drill is conducted. c. five Drillo were conducted in This Regulation is not met as evidenced by: Based on record review on 4/15/10, the facility failed to ensure that fire drills were conducted April and may. monthly during the past 6 of 12 months (October, November and December of 2009; January, Attach nents 29, 30, 31, 32 February and March of 2010). 5-9-10 Severity: 2 Scope: 2 If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Bureau of Health Care Quality and Compliance							
	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5005ADA			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/15/2010	
			STREET AD	DRESS, CITY.	STATE, ZIP CODE	04/13/2010	
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D 215 SS=D	who is capable of p resuscitation at all t providing cardiopute qualified by the America agency. This Regulation is a Based on record redid not ensure that managers (or carego	ne staff person in the roviding cardiopulmo imes. Staff members monary resuscitation erican Red Cross or a	must be another i by: facility ent	D 215	A. All staff will be a CAR by the America B. Human resource Direct employee file every be compliante. C. Program Director Will CAR renewed as the D. Employee II and CAR on 5-15-10. Ve Attached.	an Led Cross. Are or will review months Fex N schedule ected. are completing whication is	
5.540	(Employee #11). Severity: 2 Scope:	1	, , , , , , , , , , , , , , , , , , ,		Attachment 33		
D 216 SS=D	tuberculin skin test t specified in chapter	itial programs must un that meets the require 441A of NAC.	ements		A. TB startests will within 5 Days of a Dawmentation will all the classical file.		
	NAC 441A.380 Adm medical facilities, fa homes for individual respiratory isolation; counseling and prev documentation. (NR 1. Except as otherw before admitting a p extended care, skille care, the staff of the chest radiograph of	entive treatment;	certain dent or sting; ection, acility for idiate that a taken		B. Client records will by frequent manage ensure compliance compliance compliance compliance and and and and and and are free free free free free free free	er monthly 10 a TB test ray . Downentation opted from	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER ON SUPPLIER NVSS065ADA NAME OF PROVIDER OR SUPPLIER HELP OF SOUTHERN NEVADA (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) D 216 Continued From page 7 2. Except as otherwise provided in this section, the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing or intermediate care shall: (a) Before admitting a person to the facility or home, determine if the person: (1) Has had a cough which is productive; (3) Has blood in his sputum; (4) Has a fever which is not associated with a cold, flu or other apparent illness; (5) Is experiencing night sweats; (6) Is experiencing unexplained weight loss; or (7) Has been in close contact with a person who has active tuberculosis. (b) Within 24 hours after a person, including a person with a history of bacillus Calmette-Guerin	Bureau	of Health Care Quali	ty and Compliance				
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PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 216 Continued From page 7 2. Except as otherwise provided in this section, the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing or intermediate care shall: (a) Before admitting a person to the facility or home, determine if the person: (1) Has had a cough for more than 3 weeks; (2) Has a cough which is productive; (3) Has blood in his sputum; (4) Has a fever which is not associated with a cold, flu or other apparent illness; (5) Is experiencing night sweats; (6) Is experiencing unexplained weight loss; or (7) Has been in close contact with a person who has active tuberculosis. (b) Within 24 hours after a person, including a							
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(BCG) vaccination, is admitted to the facility or home, ensure that the person has a tuberculosis screening test, unless there is not a person qualified to administer the test in the facility or home when the patient is admitted. If there is not a person qualified to administer the test in the facility or home when the person is admitted, the staff of the facility or home shall ensure that the test is performed within 24 hours after a qualified person arrives at the facility or home or within 5 days after the patient is admitted, whichever is sconer. (c) If the person has only completed the first step of a two-step Mantoux tuberculin skin test within the 12 months preceding admission, ensure that the person has a second two-step Mantoux tuberculin skin test or other single-step tuberculosis screening test. After a person has had an initial tuberculosis screening test, the facility or home shall ensure that the person has a single tuberculosis screening test annually thereafter, unless the medical director or his	D 216	2. Except as otherwithe staff of a facility individual residential extended care, skill care shall: (a) Before admitting home, determine if (1) Has had a cough white (2) Has a cough white (3) Has blood in his (4) Has a fever white cold, flu or other appearance (5) Is experiencing (7) Has been in cloth has active tubercul (b) Within 24 hours person with a histor (BCG) vaccination, home, ensure that screening test, unlequalified to adminish home when the part as person qualified to adminish home when the part as person arrives at the days after the paties sooner. (c) If the person has a set uberculin skin test tuberculosis screen had an initial tubercial facility or home shall a single tuberculosis a single tuberculosis.	wise provided in this so for the dependent, a care or a medical filed nursing or interming a person to the facilithe person: the person: the person: the person: the person: the person and the person are tall the person to the facility of bacillus Calmett is admitted to the faction at the person has a tubers there is not a person the person is admitted. If the person is admitted to the faction administer the test of the person is admitted and the person is admitted, which as only completed the person to the person after a person to the person the person after a person to the person the person and the person that the person tha	a home for acility for ediate ediate ediate ediate ediate ediate ediate ediate ediate, with a ediate ediate, with a ediate ediat	D 216	· · · · · · · · · · · · · · · · · · ·	A prior to

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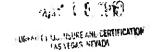
Bureau of Health Care Quality and Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS5005ADA 04/15/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1417 LAS VEGAS BLVD N **HELP OF SOUTHERN NEVADA** LAS VEGAS, NV 89101 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **TAG DEFICIENCY**) D 216 Continued From page 8 D 216 designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. A person with a documented history of a positive tuberculosis screening test is exempt from skin testing and routine annual chest radiographs, but the staff of the facility or home shall ensure that the person is evaluated at least annually for the presence or absence of symptoms of tuberculosis. 4. If the staff of the facility or home determines that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in respiratory isolation in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200 until a health care provider determines whether the person has active tuberculosis. If the staff is not able to keep the person in respiratory isolation. the staff shall not admit the person until a health care provider determines that the person does not have active tuberculosis. 5. If a test or evaluation indicates that a person has suspected or active tuberculosis, the staff of the facility or home shall not admit the person to the facility or home or, if he has already been admitted, shall not allow the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person

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Bureau of Health Care Quality and Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 04/15/2010 NVS5005ADA STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1417 LAS VEGAS BLVD N **HELP OF SOUTHERN NEVADA** LAS VEGAS, NV 89101 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5)(EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 216 Continued From page 9 D 216 does not have active tuberculosis or certifies that, although the person has active tuberculosis, he is no longer infectious. A health care provider shall not certify that a person with active tuberculosis is not infectious unless the health care provider has obtained not less than three consecutive negative sputum AFB smears which were collected on separate days. 6. If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall ensure that the person is treated for the disease in accordance with the recommendations of the Centers for Disease Control and Prevention for the counseling of, and effective treatment for, a person having active tuberculosis. The recommendations are set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (a) of subsection 1 of NAC 441A.200. The staff of the facility or home shall ensure that counseling and preventive treatment are offered to each person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 8. The staff of the facility or home shall ensure that any action carried out pursuant to this section and the results thereof are documented in the person 's medical record. (Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006) Based on record review on 4/15/10, the facility did not ensure that 1 of 8 residents met the requirements of NAC 441A.380 concerning tuberculosis (TB) (Resident #6). Severity: 2 Scope: 1

> AND CERTIFICATION AS YEGAS, NEVADA

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVS5005ADA 04/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1417 LAS VEGAS BŁVD N HELP OF SOUTHERN NEVADA LAS VEGAS, NV 89101 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DAIT D 217 NAC 449.141(9) Health Services D 217 A. All Staff will be 1st And corrised 9. Each facility shall maintain and have readily by the American Red Cross. available first-aid supplies. Staff members shall have evidence that they have received training on B. Human resource Director WM the use of first-aid supplies. Check employee Files every le months to ensure compliance. This Regulation is not met as evidenced by: C. Program Director Will Schedule Based on record review on 4/15/10, the facility did not ensure that 2 of 6 assistant resident 15t And renewal as needed. managers (or caregivers) had evidence of first aid training (Employee #11 and #12). D. Employee 11 is scheduled to Severity: 2 Scope: 2 take 187 And Class on 5-15-10. Attachment 36 5-15-10 E. Employee 12 is certified in 15 And . Documentation was in File. Attachment 37 11-10-08 F. Employee 1 is scheduled to take 1st Aid Class on 5-15-10. Attachment 38 5-15-10

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